COSULICH DERMATOLOGY, LLC

HIPAA ACKNOWLEDGEMENTS AND AUTHORIZATIONS

We are required by law to maintain the privacy of protected health information and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. By signing below, patient acknowledges that he/she has been given the option of receiving a copy or been afforded an opportunity to review this Notice of Cosulich Dermatology's HIPAA Notice of Privacy Practices.

Print Name	Patient Signature	DOB	Today's Date

Patient Contact Information

Preferred #: (Telephone) _____ Alternate #: (Telephone) _____

I authorize messages with medical information to be left on voicemail at (check all that apply):

☐ Preferred # ☐ Alternate # ☐ None, please do not leave voice messages

I authorize brief message details: ☐ Preferred # ☐ Alternate #

I authorize extended message details: ☐ Preferred # ☐ Alternate #

Restrictions/Instructions: _____

Release of Medical History, Treatment, and Billing Information

I authorize the following individual(s) to receive information regarding any medical history, treatment, billing issues and to act on my behalf:

Name: _____ Relationship: _____ DOB: _____ Phone #: _____

Name: _____ Relationship: _____ DOB: _____ Phone #: _____

Restrictions/Instructions: _____

Patient Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office. My revocation will be effective once received by Cosulich Dermatology, LLC.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name	Patient Signature	Date